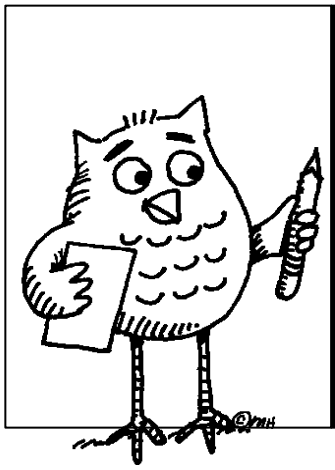

Waiver Wise

Technical Assistance for the Community Options Program Waiver COP-W

Wisconsin Department of Health & Family Services • Division of Supportive Living
Bureau of Aging & Long Term Care Resources

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Oldies but Goodies: Commonly Asked Questions

Background

The following is a sampling of questions commonly posed by counties about a variety of waiver-related issues, such as whether or not an item or service is waiver allowable or whether a participant meets eligibility requirements. The selection provided in this document is eclectic by design and addresses the following areas:

- *Financial Questions*
- *Allowable Services Questions*

Financial Questions

Question 1 – Can the cost of long distance telephone calls made to a participant's doctor(s), dentist, MA service providers, and waiver program service providers be used as a Medical/Remedial expense?

The cost of long distance telephone calls made to a participant's medical service providers and providers of long-term care services is an allowable medical/remedial expense. This can include MA providers of care, as well as providers of waiver program services. The cost of calls will need to be projected for a 12-month period and averaged over the year, with a monthly total estimated by the care manager and the participant. The criteria for allowing these costs to be considered medical/remedial expenses include:

- A participant with a complex health situation may receive care from specialists who practice outside of the participant's local area and can only be contacted by calling long distance.

- A participant with a complicated health care situation or difficult service plan may need to be in direct telephone contact with their service providers more frequently than others and may have excessive telephone costs associated with these calls.

- There is a growing trend in health care for providers to used telephone contacts in lieu of face-to-face contacts with consumers. Because of this trend, a participant may have excessive telephone costs associated with these calls.

Question 2 – Can the cost of basic telephone service be funded by the waiver program? Can the cost of basic telephone service be used as a medical/remedial expense?

No. The cost of a participant's basic telephone service cannot be paid with waiver funds, nor can these costs be counted as medical/remedial expenses. The one exception to this is the cost of basic telephone service for a participant who has a personal emergency response system (PERS). Since a phone line is needed in order to have a PERS unit, the cost of the flat monthly service rate can be counted as a medical/remedial expense.

Please note: If a participant does not have a PERS, the monthly telephone service rate **cannot** be counted as a medical/remedial expense.

Question 3 – A waiver participant pays a cost share payment towards the cost of his/her waiver services. His/her cost share payment is greater than the cost of the services provided in a given month. When the cost share is paid towards all the waiver services a participant receives, does the participant have to pay towards MA services they receive or does the participant get to keep the difference?

In any given month, the participant does not need to pay towards their MA services. Any excess cost share amount is retained by the participant.

Example: A participant has a monthly cost share of $200.00. The service plan consists of care management, Lifeline, and supportive home care. In the month of May, the total sum of all three services was $175.00. In this example, the participant only has to pay $175.00 of their $200.00 cost share. He/she gets to retain the remaining $25.00.

Allowable Services Questions

Question 4 – Can waiver funds be used to pay for transportation costs involved in transporting a participant to and from her/her employment?

Yes. Under SPC 107, a person's place of employment is considered a community resource. This is one of the rare instances in which CIP II/COP-W funds can pay for a service that is related to employment.

Question 5 – Sometimes a care manager provides a ride for a participant. Is this allowable? If so, how should it be billed?

If possible, ongoing transportation should be obtained from appropriate transportation vendors. On rare occasions, a care manager will provide transportation for the participant. Though this does not occur frequently, it is allowable. However, it is important to bill this service correctly. When a care manager does provide transportation, it is important to remember the "Bill MA First Rule." Any medical transportation provided (doctor, clinic, etc) should be billed as MA transportation. Other transportation (shopping, errands, etc) may be billed to the Waiver. The care manager

should bill *mileage* to SPC 107 – specialized transportation. Because the service is being billed under SPC 107, it is important that the participant's case file have appropriate documentation that illustrates the care manager and his/her vehicle meets the standards as outlined in the MA Waivers Manual.

Example 1: A daughter usually provides transportation for the participant to her doctor appointments. An unexpected problem arises, the daughter cannot provide the ride, and it is too late to make arrangements with the local transportation providers in the area. The participant calls the care manager and asks if she can be of any help. The care manager tries to secure a ride by other means, but is unsuccessful. As a result, the care manager agrees to provide the ride to the doctor, accompanies the participant while she is talking with her doctor, and takes her home. The care manager leaves her office, drives to participant's home, transports her to the clinic, stays with the participant while at the clinic, takes the participant home, and then goes back to the office. Transportation from the care manager's office to the participant's home, to the clinic and back to participant's home, and then back to the office is 64 miles. The breakdown is as follows: 25 miles from office to participant's home and 25 miles from participants home to office = 50 miles. 7 miles from participant's home to clinic and 7 miles from clinic to participant's home = 14 miles. Total time care manager is away from office providing assistance is 2 ½ hours.

The Correct Way to Bill: The miles are billed under SPC 107 according to the purpose of the transportation provided, either MA medical mileage or Waiver mileage. The care manager's time with the participant is billed as care management under SPC 604. Hours cannot be recorded for SPC 107; therefore, any time that the care manager is on route or waiting for the participant is considered "non care management time" and is absorbed in the county's care management rate.

Please note: Care managers should identify the appropriate funding source – either MA medical mileage or Waiver mileage – on their mileage sheets.

Question 6 – Can waiver funds be used to pay for acupuncture?

Yes. Under SPC 507- Counseling/Therapeutic Resources, acupuncture may be an allowable expenditure if certain criteria and standards are met. The criteria and standards include:

- Documentation that the acupuncturist is licensed and/or certified
- Documentation that the service cannot be paid by Medicaid
- Documentation that treatments are meeting a therapeutic goal

Question 7 – Will the waiver program fund adaptive recreational equipment as an adaptive aid? Could the waiver program pay for a part of recreational equipment that is deemed adaptive?

No. The waiver program does not pay for recreational equipment. Recreation is not considered one of the activities of daily living (ADL). In addition, the waiver program will not pay for the adaptive part of the equipment. The adaptation does not assist the participant to increase his/her independence in performing an ADL.